115TH CONGRESS
1ST SESSION

S. 1334

To amend title XVIII of the Social Security Act to provide for advanced illness care coordination services for Medicare beneficiaries, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JUNE 12, 2017

Mr. WARNER (for himself, Mr. ISAKSON, Ms. BALDWIN, Ms. COLLINS, Ms. KLOBUCHAR, and Mrs. CAPITO) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To amend title XVIII of the Social Security Act to provide for advanced illness care coordination services for Medicare beneficiaries, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Patient Choice and Quality Care Act of 2017''.

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. FINDINGS.

Congress makes the following findings:

(1) The population of the United States is estimated to age rapidly, with the number of people over the age of 65 set to double to more than 98 million, or 1 in 5 Americans, by 2040.

(2) As Americans live longer and healthier lives, they also face increased incidence of multiple serious or chronic progressive conditions and advanced illness as they age.

(3) Americans with serious, chronic progressive, or advanced illness face a complicated and fragmented system of care delivery that puts them at risk for repeat hospitalizations, adverse drug reactions, and conflicting medical advice that may be overwhelming to individuals and families.

(4) The progression of serious, chronic progressive, or advanced illness leads to the need for increasingly intensive decision support, health care services, and support from family caregivers.

(5) The complexity of care needed by individuals with serious, chronic progressive, or advanced illness may result in uncoordinated care, adverse health outcomes, frustration, wasted time, and undue emotional burdens on individuals and their family caregivers.

(6) Numerous private sector leaders, including hospitals, health systems, home health agencies, hospice programs, long-term care providers, employers, and other entities, have put in place innovative solutions to provide more comprehensive and coordinated care for Americans living with serious, chronic progressive, or advanced illness.

(7) Hospice and palliative care programs offer patients and families appropriate and patient-centered care, delivered by an interdisciplinary care team. These programs should serve as models for serious, chronic progressive, or advanced illness care delivery.

(8) Individuals have the well-established right to accept or reject medical treatment that is offered and all individuals should be afforded the opportunity to fully participate in decisions related to their health care.

(9) Too often, individuals with serious, chronic progressive, or advanced illness do not understand the conditions they are facing or their treatment options, and they do not receive the information or support they need to evaluate treatment options in light of their personal goals and values and to document treatment plans in a manner that allows providers and facilities to follow their plans.

(10) Providing high-quality advanced care planning services and supports to individuals with serious, chronic progressive, or advanced illness will protect and preserve their dignity and ensure care is aligned with an individual's goals, values, and stated preferences.

SEC. 3. ADVANCED ILLNESS CARE AND MANAGEMENT MODEL.

Section 1115A of the Social Security Act (42 U.S.C. 1315a) is amended—

(1) in subsection (b)(2)(A), by adding at the end the following new sentence: ''The models selected under this subparagraph shall include the model described in subsection (h), which shall be implemented by not later than 1 year after the date of the enactment of the Patient Choice and Quality Care Act of 2017.'';

(2) by adding at the end the following new subsection:

"(h) ADVANCED ILLNESS CARE AND MANAGEMENT MODEL.—

"(1) MODEL.—

"(A) IN GENERAL.—The model described in this subparagraph is a model under which payments are made under title XVIII to applicable providers that furnish advanced illness care and management services, including care coordination and palliative care services, to eligible individuals with serious, chronic progressive, or advanced illness in order to test the use of targeted advanced illness management and early use of palliative care under the Medicare program.

"(B) VOLUNTARY.—Participation under the model shall be voluntary with respect to both eligible individuals and applicable providers.

"(C) REQUIREMENTS.—

"(i) HOSPICE PROVIDER.—At least one applicable provider selected for participation under the model shall be a hospice

program (as defined in section 1861(dd)(2)).

''(ii) COMPARISON.—The Secretary shall establish the model in such a manner as will permit the comparison of outcomes for eligible individuals participating under the model and eligible individuals who are not so participating.

''(iii) INCORPORATION INTO EXISTING MODELS.—In addition to operating the model independently, the Secretary shall incorporate the model into existing models related to the Medicare program, such as models involving accountable care organizations, bundled payments, and value based purchasing arrangements, and other coordinated care models as the Secretary determines to be appropriate.

''(2) PAYMENTS.—Under the model, the Secretary shall establish payment amounts for advanced illness care and management services that is targeted to eligible individuals with a serious, chronic progressive, or advanced illness. The payments may include payments under a fee schedule, capitated payments, bundled payments, value-based pur-

chasing agreements, and other payment mechanisms determined appropriate by the Secretary.

''(3) ADVANCED ILLNESS CARE AND MANAGEMENT SERVICES DEFINED.—In this subsection, the term 'advanced illness care and management services' means the following services, as appropriate for the individual's illness and stage of illness:

''(A) One or more face-to-face encounters between one or more members of the interdisciplinary team and the individual and, at the individual's discretion, family caregivers, or, for an individual who lacks decisionmaking capacity under State law, the individual's legally authorized representative.

''(B) The provision of information about the typical trajectory of illnesses or conditions that affect the individual, including foreseeable care decisions that may need to be made at a future time when the individual is likely to be unable to make decisions due to temporary or permanent cognitive or medical incapacity.

''(C) Assisting the individual in defining and articulating goals of care, values, and preferences.

''(D) Providing the individual with and discussing information about the benefits and burdens of relevant ranges of treatment options available to the individual, including disease modifying or potentially curative treatment, palliative care, which may be provided alone or in conjunction with disease modifying treatment, and, when the individual may be currently eligible or may become eligible for hospice care due to disease progression.

''(E) Assisting the individual in evaluating treatment options and approaches to care to identify those that most closely align with the individual's goals of care, values, and preferences.

''(F) Preparing, and sharing with relevant providers, documentation—

''(i) that states the individual's goals of care, preferences, and values, preferred decisionmaking strategies, and a plan of care that is concrete and actionable; and

''(ii) that is in State or locally recognized forms that are used for the purpose of assuring that providers can follow the

plan across care settings, such as advance directives or portable treatment orders.

''(G) Referrals to providers, including medical and social service providers, who deliver care consistent with the plan.

''(H) Providing culturally and educationally appropriate training for the individual and family caregivers to support their ability to carry out the plan.

''(I) A multidimensional assessment of the individual's strengths and limitations.

''(J) An assessment of the individual's paid and unpaid supports, including family caregivers.

''(K) Comprehensive medication review and management (including, if appropriate, counseling and self-management support).

''(L) Visits to the patient in all sites of care (including the home, a hospital, and a nursing home) as needed to respond appropriately to problems and concerns.

''(M) Additional services, consistent with the care plan, that the interdisciplinary team believes would assist the eligible individual and

family caregivers in more effectively managing their health condition.

''(N) 24-Hour access to emergency support in person or via telephone or telemedicine with the individual's medical record and care plan available to the responder.

''(O) Care coordination and communication across health care and social service settings and providers, including involvement of the interdisciplinary team to evaluate quality and address concerns over time.

''(P) Such other palliative and other services that the Secretary determines appropriate.

''(4) APPLICABLE PROVIDER DEFINED.—In this subsection, the term 'applicable provider' means a hospice program (as defined in section 1861(dd)(2)) or other provider of services (as defined in section 1861(u)) or supplier (as defined in section 1861(d)) that—

''(A) furnishes services through an interdisciplinary team; and

''(B) meets such other requirements the Secretary may determine to be appropriate.

''(5) ELIGIBLE INDIVIDUAL DEFINED.—In this subsection, the term 'eligible individual' means an individual who—

''(A) is entitled to, or enrolled for, benefits under part A of title XVIII and enrolled under part B of such title, but not enrolled under part C of such title;

''(B) resides at home or in an institutional setting, whichever is consistent with their personal goals and preferences; and

''(C) meets at least one of the following:

''(i) The individual has the need for assistance with two or more activities of daily living (defined as bathing, dressing, eating, getting out of bed or a chair, mobility, and toileting) that is caused by one or more serious or life threatening conditions or frailty and that is not associated with an acute or post-operative condition.

''(ii) The individual is diagnosed with a serious, chronic progressive or advanced illness that—

''(I) has a strong negative impact on the individual's quality of life and

functioning in life roles, independent of its impact on mortality; or

"(II) is burdensome in symptoms, treatments or caregiver stress.

"(iii) The individual is diagnosed with—

"(I) metastatic or locally advanced cancer;

"(II) Alzheimer's disease or another progressive dementia;

"(III) late-stage neuromuscular disease;

"(IV) late-stage diabetes;

"(V) late-stage kidney, liver, heart, gastrointestinal, cerebrovascular, or lung disease; or

"(VI) age-related physical debility.

"(iv) The individual meets other criteria determined appropriate by the Secretary.

"(6) INTERDISCIPLINARY TEAM.—

"(A) IN GENERAL.—Subject to subparagraph (B), in this subsection, the term 'interdisciplinary team' means a group that—

''(i) includes at least—

''(I) one physician who is board certified in geriatrics, internal medicine, or family medicine;

''(II) one physician, advance practice registered nurse, or physician assistant, who is a palliative specialist (defined as having a certification in hospice and palliative care) or who has at least one year's experience providing hospice or palliative care;

''(III) one nurse; and

''(IV) one social worker;

''(ii) may include a chaplain, minister, or pastoral counselor;

''(iii) may include other direct care personnel (including pharmacists, dieticians, physical therapists, occupational therapists, and psychotherapists); and

''(iv) meets requirements that may be established by the Secretary.

''(B) ADDITIONAL MEMBER AT THE REQUEST OF THE ELIGIBLE INDIVIDUAL.—An applicable provider shall offer to the eligible individual (or the individual's legally authorized

representative when the individual has been found to lack decisional capacity) the opportunity to select either a chaplain affiliated with the applicable provider, a minister, or personal religious or spiritual advisor who can help to represent the individual's goals, values, and preferences to serve as a core interdisciplinary team member at the individual's (or legally authorized representative's) request.''.

SEC. 4. QUALITY MEASUREMENT DEVELOPMENT AND IMPLEMENTATION.

(a) FACILITATION OF INCREASED COORDINATION AND ALIGNMENT BETWEEN THE PUBLIC AND PRIVATE SECTOR WITH RESPECT TO QUALITY MEASURES REGARDING ADVANCED ILLNESS, PALLIATIVE, AND END-OF-LIFE CARE.—

(1) IN GENERAL.—Section 1890(b) of the Social Security Act (42 U.S.C. 1395aaa(b)) is amended by inserting after paragraph (3) the following new paragraph:

''(4) INCREASED COORDINATION AND ALIGNMENT BETWEEN THE PUBLIC AND PRIVATE SECTOR WITH RESPECT TO QUALITY MEASURES REGARDING ADVANCED ILLNESS, PALLIATIVE, AND END-OF-LIFE CARE.—

''(A) IN GENERAL.—The entity shall facilitate increased coordination and alignment between the public and private sector with respect to quality measures regarding advanced illness, palliative, and end-of-life care across the care settings and programs described in this section and across other services and care settings under this title, as appropriate.

''(B) ENVIRONMENTAL SCAN.—The entity shall conduct an environmental scan of measures, measure concepts, and preferred practices for advanced illness, palliative, and end-of-life care used in both the private and public sectors and from multiple settings of care. Such scan shall include a review of the following:

''(i) The process of eliciting and documenting patient (and, where relevant and appropriate, family caregiver or legally authorized representative) goals, preferences, and values regarding care and treatment, including the articulation of goals for end-of-life care that adequately reflect how the patient wants to live.

''(ii) The effectiveness, patient-centeredness (and, where relevant, family

caregiver-centeredness), and adequacy of care plans, including documentation of individual goals, preferences, and values.

"(iii) Agreement and consistency among—

"(I) the patient's goals, preferences, and values;

"(II) any documented care plan; and

"(III) the care delivered.

"(iv) Timely and appropriate referral to hospice care.

"(C) IDENTIFICATION AND PRIORITIZATION OF MEASURES.—The entity shall, based on the scan conducted under subparagraph (B), identify and prioritize measures, measure concepts, and preferred practices, that are aligned across settings of care, condition, and patient population.

"(D) REPORT.—Not later than 18 months after the date of enactment of this paragraph, the entity shall submit to the Secretary a report containing the findings of the entity with respect to the environmental scan under subparagraph (B) and the identification and

prioritization of measures, measure concepts, and preferred practices under subparagraph (C).''.

(b) STUDY AND REPORT ON NIH DEVELOPMENT OF ADDITIONAL MEASURES RELATED TO CARE PLANNING.—Section 1890A of the Social Security Act (42 U.S.C. 1395aaa–1) is amended by adding at the end the following new subsection:

''(g) STUDY AND REPORT ON NIH DEVELOPMENT OF ADDITIONAL MEASURES RELATED TO CARE PLANNING.—

''(1) STUDY.—The Secretary, in consultation with the Palliative Care Research Cooperative Group, the National Institute of Nursing Research, and the Office of End-of-Life and Palliative Care Research of the National Institutes of Health shall conduct a study regarding the development of measures related to—

''(A) concordance of care between the wishes of an individual and the treatment received by the individual, including documentation of such wishes in the medical record;

''(B) understanding the population with serious, chronic progressive, or advanced illness

that would benefit from palliative care and advance care planning services; and

"(C) appropriate transitions to hospice care.

"(2) REPORT.—Not later than December 31, 2019, the Secretary shall submit to Congress a report containing the results of the study conducted under paragraph (1).".

(c) MEDICARE PHYSICIAN FEE SCHEDULE.—Section 1848(s)(1) of the Social Security Act (42 U.S.C. 1395w–4(s)(1)) is amended by adding at the end the following new subparagraph:

"(G) CLINICAL CARE MEASURES RELATING TO PALLIATIVE AND END-OF-LIFE CARE.—Beginning after the completion of the environmental scan under section 1890(b)(4)(B), within one or more appropriate quality domains, the Secretary shall, in consultation with the entity with a contract under section 1890(a), establish appropriate clinical care measures relating to palliative and end-of-life care, including at least one measure for each of the areas studied under subparagraphs (A), (B), and (C) of section 1890A(g)(1).".

(d) POST-ACUTE CARE.—Section 1899B of the Social Security Act (42 U.S.C. 1395lll) is amended—

(1) in subsection (a)(2)(E)(i)—

(A) in subclause (IV), by striking ''and'' at the end;

(B) in subclause (V), by striking the period at the end and inserting ''; and''; and

(C) by adding at the end the following new subclause:

''(VI) with respect to the domain described in subsection (c)(1)(F) (relating to end-of-life care)—

''(aa) for PAC providers described in clauses (ii), (iii), and (iv) of paragraph (2)(A), October 1, 2020; and

''(bb) for PAC providers described in clauses (i) of such paragraph, January 1, 2021.''; and

(2) in subsection (c)(1), by adding at the end the following new subparagraph:

''(F) The effectiveness, patient-centeredness (and, where relevant, family caregiver-centeredness), and adequacy of care plans

and communications relating to such plans, including—

"(i) documentation of a patient's goals, preferences, and values;

"(ii) agreement and consistency with respect to care among—

"(I) the patient's goals, preferences, and values;

"(II) any documented care plan; and

"(III) the care delivered; and

"(iii) timely and appropriate referral to hospice care.".

(e) MEDICARE ADVANTAGE.—Section 1852(e)(3) of the Social Security Act (42 U.S.C. 1395w–22(e)(3)) is amended by adding at the end the following new subparagraph:

"(C) PALLIATIVE AND END-OF-LIFE CARE.—The Secretary, in consultation with the National Committee for Quality Assurance, shall prioritize the development of standards for palliative and end-of-life care, including transition to hospice care, with respect to Medicare Advantage organizations under this part for use under the quality improvement program under

paragraph (1) that are the equivalent of such standards in quality programs applicable to providers of services and suppliers under the original Medicare fee-for-service program under parts A and B.''.

(f) ALTERNATIVE PAYMENT MODELS.—Section 1899(b)(3)(C) of the Social Security Act (42 U.S.C. 1395jjj(b)(3)(C)) is amended—

(1) by striking ''STANDARDS.—The Secretary'' and inserting ''STANDARDS.—

''(i) IN GENERAL.—The Secretary''; and

(2) by adding at the end the following new clause:

''(ii) PALLIATIVE AND END-OF-LIFE CARE.—The Secretary, in consultation with the entity with a contract under section 1890(a), shall ensure that quality performance standards established under this subparagraph include measures that apply to palliative and end-of-life care, including transition to hospice care.''.

SEC. 5. ENHANCING COVERAGE OF ADVANCE CARE PLANNING SERVICES.

(a) DEFINITION.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Advance Care Planning Services

''(jjj)(1) The term 'advance care planning services' means services identified as of the date of enactment of this subsection as Current Procedural Terminology (CPT) codes 99497 and 99498, and such codes as subsequently modified, that are furnished by a physician or other eligible practitioner (as determined by the Secretary).

''(2) For purposes of paragraph (1), the term 'eligible practitioner' includes, in addition to a practitioner eligible to bill such CPT codes as of the date of enactment of this subsection, an individual who—

''(A) is a clinical social worker (as defined in subsection (hh)(1)); and

''(B) possesses—

''(i) a relevant care planning certification; or

''(ii) experience providing care planning conversations or similar services, as defined by the Secretary, in the course of their work.''.

(b) NO APPLICATION OF COINSURANCE OR DEDUCTIBLE.—

(1) AMOUNT.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395*l*(a)(1)) is amended—

(A) by striking ''and (BB)'' and inserting ''(BB)''; and

(B) by inserting before the semicolon at the end the following: '', and (CC) with respect to advance care planning services (as defined in section 1861(jjj)(1)), the amounts paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined under the fee schedule established under section 1848(b).''.

(2) WAIVER OF APPLICATION OF DEDUCTIBLE.—The first sentence of section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)) is amended—

(A) by striking ''and'' before ''(10)''; and

(B) by inserting before the period the following: '', and (11) such deductible shall not apply with respect to advance care planning services (as defined in section 1861(jjj)(1))''.

(c) EFFECTIVE DATE.—The amendment made by this subsection shall apply to advance care planning services furnished on or after January 1, 2018.

SEC. 6. ADVANCE CARE PLANNING SUPPORT TOOLS.

(a) INCLUSION OF ADVANCE CARE PLANNING MATERIALS IN THE MEDICARE & YOU HANDBOOK.—

(1) IN GENERAL.—Section 1804(a) of the Social Security Act (42 U.S.C. 1395b–2(a)) is amended—

(A) in paragraph (2), by striking ''and'' at the end;

(B) in paragraph (3), by striking the period at the end and inserting a semicolon; and

(C) by inserting after paragraph (3) the following new paragraphs:

''(4) information on—

''(A) care planning;

''(B) how individual goals, values, and preferences should be considered in framing a care plan; and

''(C) a range of approaches for treating serious, chronic progressive, or advanced illness, including disease modifying options, palliative care that supports individuals from the onset of serious, chronic progressive, or advanced illness and can be provided at the same time as all other care types, and hospice care; and

''(5) information on documentation options for care planning or advance care planning, including advance directives and portable treatment orders.''.

(2) EFFECTIVE DATE.—The amendments made by this section shall apply to notices distributed on or after January 1, 2018.

(b) ADVANCE CARE PLANNING STANDARDS FOR ELECTRONIC HEALTH RECORDS.—

(1) IN GENERAL.—Notwithstanding section 3004(b)(3) of the Public Health Service Act (42 U.S.C. 300jj–14(b)(3)), not later than 4 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall adopt, by rule, standards for a qualified electronic health record (as defined in section 3000(13) of such Act (42 U.S.C. 300jj(13)), with respect to organizing patient communications with health care providers about care goals and to provide one-click access to the following:

(A) The patient's current advance directive (as defined in section 1866(f)(3) of the Social Security Act (42 U.S.C. 1395cc(f)(3)), as applicable.

(B) The patient's current order for life-sustaining treatment (described in section 9(d)(3)(B)), as applicable.

(C) Documentation of advance care planning discussion between the patient and the provider.

(2) TREATMENT OF STANDARDS.—A standard adopted under paragraph (1) shall be treated as a standard adopted under section 3004 of the Public Health Service Act (42 U.S.C. 300jj–14) for purposes of certifying qualified electronic health records pursuant to section 3001(c)(5) of such Act (42 U.S.C. 300jj–11(c)(5)).

SEC. 7. ADVANCE DIRECTIVES.

(a) PORTABILITY.—Section 1866(f) of the Social Security Act (42 U.S.C. 1395cc(f)) is amended by adding at the end the following new paragraph:

''(5)(A) An advance directive validly executed outside the State in which such directive is presented may be given effect by a provider of services or organization to the same extent as an advance directive validly executed under the law of the State in which it is presented.

''(B) In the absence of knowledge to the contrary, a physician or other health care provider or organization may presume that a written advance health care directive

or similar instrument, regardless of where executed, is valid.

''(C) The provisions of this paragraph shall preempt any State law on advance directive portability to the extent such law is inconsistent with such provisions.

''(D) Nothing in the paragraph shall be construed to—

''(i) authorize the administration of health care treatment otherwise prohibited by the laws of the State in which the directive is presented;

''(ii) require a provider of services or an organization to act in a manner contrary to its religious or moral convictions;

''(iii) apply to a request or directive ordering a sterilization or abortion or ordering withdrawal of treatment from a pregnant woman if continued treatment can reasonably be expected to bring her child to live birth;

''(iv) prohibit the application of a State law which allows for an objection on the basis of conscience for any health care provider or any agent of such provider which as a matter of conscience cannot implement an advance directive or portable treatment order; or

''(v) permit the Secretary to seek civil penalties, including exclusion from participation in the program under this title or the program under title XIX, against a provider or organization if the provider or organization—

''(I) used reasonable efforts to deliver care that is consistent with an individual's goals, preferences, and values when addressing decisionmaking for an individual who lacks decisional capacity; or

''(II) exercised its right of conscience in accordance with clause (ii) or (iv).''.

(b) CLARIFICATION WITH RESPECT TO ADVANCE DIRECTIVES.—Paragraph (2) of section 7 of the Assisted Suicide Funding Restriction Act of 1997 (42 U.S.C. 14406) is amended to read as follows:

''(2) to require any provider or organization, or any employee of such a provider or organization, to follow or be bound by a request from an individual or legally authorized representative, an advance directive, or a portable treatment order that directs the purposeful causing of, or the purposeful assisting in causing, the death of any individuals, such as by assisted suicide, euthanasia, or mercy killing.''.

(c) GAO STUDY ON HEALTH CARE DECISIONMAKING LAWS AND BARRIERS TO THE USE OF ADVANCE DIRECTIVES.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study that examines the use, portability, and electronic storage of advance directives and that identifies barriers towards adopting, using, and following advance directives in the clinical setting. Such examination shall include issues that remain unresolved after the Stage 3 Meaningful Use final rule, including barriers and solutions to finding and accessing advance care planning documents, best practices for alerting eligible providers to the presence of an advance care plan, and best practices for transmitting advance care plans across sites of care.

(2) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) and shall include in the report such recommendations regarding improving advance health care planning as the Comptroller General deems appropriate.

SEC. 8. ADDITIONAL REQUIREMENTS FOR FACILITIES.

(a) REQUIREMENTS.—

(1) IN GENERAL.—Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) is amended—

(A) in subparagraph (Y), by striking the period at the end and inserting ''; and''; and

(B) by inserting after subparagraph (Y) the following new subparagraph:

''(Z) in the case of hospitals, skilled nursing facilities, home health agencies, and hospice programs, to assure that documented care plans include any advance directives or portable treatment orders made while the individual received care by the provider and that such plan is sent to the individual's primary care provider upon discharge and any facility to which the individual is transferred.''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to agreements entered into or renewed on or after January 1, 2019.

(b) HHS STUDY AND REPORT.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study on the extent to which hospitals, skilled nursing facilities, hospice programs, home health agencies, and providers of advance care planning services work with individuals to—

(A) engage in a care planning process;

(B) thoroughly and completely document the care planning process in the medical record and to update the care plan on a regular basis;

(C) complete documents necessary to support the treatment and care plan, such as portable treatment orders and advance directives;

(D) provide services and support that are free from discrimination based on advanced age, disability status, or diagnosis, including serious, chronic progressive, or advanced illness; and

(E) provide documentation necessary to carry out the treatment plan to—

(i) subsequent providers or facilities; and

(ii) the individual, their legally authorized representatives, and, where appropriate and relevant, their family caregiver.

(2) REPORT.—Not later than January 1, 2021, the Secretary of Health and Human Services shall submit to Congress a report on the study conducted under paragraph (1) together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

SEC. 9. GRANTS FOR INCREASING PUBLIC AWARENESS AND TRAINING.

(a) MATERIAL AND RESOURCES DEVELOPMENT.—The Secretary of Health and Human Services (referred to in this section as the ''Secretary''), in consultation with the Advance Care Planning Advisory Council (established in section 10), may award grants to public or private entities (including, as appropriate, States, political subdivisions of States, medical schools, nursing schools, health care systems, faith-based organizations, and religious educational institutions), or a consortium of any such entities, to develop online training modules, decision support tools, and instructional materials for individuals, family caregivers, and health care providers that include—

(1) with respect to healthy individuals, the importance of—

(A) identifying an individual who will make treatment decisions in the event of future cognitive incapacity;

(B) discussing values and goals relevant to serious injury or illness; and

(C) completing an advance directive that—

(i) appoints a surrogate; and

(ii) documents goals and values and other information that should be considered in making treatment decisions;

(2) with respect to individuals with serious, chronic progressive, or advanced illness, the importance of—

(A) articulating goals of care;

(B) understanding prognosis and typical disease trajectory;

(C) evaluating treatment options in light of goals of care;

(D) developing a treatment plan; and

(E) documenting the treatment plan on advance directives, portable treatment orders, and other documentation forms used in the locality where the plan is to be executed;

(3) the role and effective use of State and other advance directive forms and portable treatment orders;

(4) the range of services for individuals facing serious, chronic progressive, or advanced illness, including advance care planning services, palliative care, and hospice care; and

(5) with respect to providers of advance care planning, advance illness care, hospice care, and palliative care in hospital, hospice, home, community, and long-term care settings, material to assist in—

(A) developing and implementing programs and initiatives to train and educate individuals;

(B) providing training and continuing education to individuals who will provide advance care planning services or palliative care in the hospital, hospice, home, community, and long-term care settings; and

(C) developing curricula or teaching materials related to advance care planning or palliative care in such settings.

(b) ESTABLISHMENT AND MAINTENANCE OF WEB- AND TELEPHONE-BASED RESOURCES.—

(1) IN GENERAL.—The Secretary may award grants to public or private entities (including States, political subdivisions of States, faith-based organizations, and religious educational institutions), or a consortium of any such entities, to establish and maintain an Internet website and telephone hotline to disseminate resources developed under subsection (a) and materials for faith communities designed by the Department of Health and Human Services Center for Faith-Based and Neighborhood Partnerships.

(2) ABILITY TO SUSTAIN ACTIVITIES.—In determining whether to award a grant under paragraph (1), the Secretary shall take into account the ability

of an entity to sustain the activities described in paragraph (1) beyond the initial grant period.

(c) NATIONAL PUBLIC EDUCATION CAMPAIGN.—The Secretary may award grants to public or private entities (including States, political subdivisions of States, faith-based organizations, and religious educational institutions) to conduct a national public education campaign to raise public awareness of advance care planning and serious, chronic progressive, or advanced illness care, including the availability of the resources created under this section.

(d) ORDERS FOR LIFE-SUSTAINING TREATMENT.—

(1) IN GENERAL.—The Secretary may award grants to eligible entities for the purposes of carrying out the activities under paragraph (2).

(2) AUTHORIZED ACTIVITIES.—Activities funded through a grant under this section for an area may include—

(A) establishing and operating a National Resource Center on POLST Programs to provide—

(i) technical assistance and professional training to programs for orders for life-sustaining treatment;

(ii) analysis and dissemination of best practices in implementing program for orders for life-sustaining treatment;

(iii) voluntary standards for the establishment and operation of program for orders for life-sustaining treatment; and

(iv) compilations and summaries of recently conducted research and other resources relevant to program for orders for life-sustaining treatment;

(B) developing such a program for the area that includes hospitals, home care, hospice, long-term care, community and assisted living residences, skilled nursing facilities, and emergency medical services within a State; and

(C) expanding an existing program for orders regarding life-sustaining treatment to serve more patients or enhance the quality of services, including educational services for patients and patients' families, training of health care professionals, or establishing an orders for life-sustaining treatment registry.

(3) DEFINITIONS.—In this subsection—

(A) the term ''eligible entity'' means—

(i) an academic medical center, a medical school, a State health department, a State medical association, a multistate task force, a hospital, or a health system capable of administering a program for physician orders regarding life-sustaining treatment for a State; or

(ii) any other health care agency or entity as the Secretary determines appropriate; and

(B) the term ''program for orders for life-sustaining treatment'' means a program that, regardless of its name—

(i) implements a clinical process designed to facilitate shared, informed medical decisionmaking and communication between health care professionals and patients with serious, progressive illness or frailty and results in a set of medical orders that—

(I) are consistent with the national standard as reflected by the National POLST Paradigm, representing health care providers, organizations, and stakeholders;

(II) are portable and honored across care settings; and

(III) address key medical decisions consistent with the patient's goals of care; and

(ii) is guided by a coalition of stakeholders, such as patient advocacy groups and representatives from across the continuum of health care services, disability rights advocates, senior advocates, emergency medical services, long-term care, medical associations, hospitals, home health, hospice, palliative care, nursing associations, the State agency responsible for senior and disability services, faith-based groups, and the State department of health.

(e) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated to the Secretary, for purposes of awarding grants under this section, $50,000,000 for the period of fiscal years 2018 through 2022.

(2) LIMITATION.—None of the funds appropriated under paragraph (1) shall be used to—

(A) develop a model advance directive;

(B) develop or employ a dollars-per-quality adjusted life year (or similar measure that discounts the value of a life because of an individual's disability); or

(C) make a grant to a private entity that advocates, promotes, or facilitates any item or procedure for which funding is unavailable under the Assisted Suicide Funding Restriction Act of 1997 (Public Law 105–12).

SEC. 10. ADVANCE CARE PLANNING ADVISORY COUNCIL.

(a) ESTABLISHMENT.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish within the Office of the Secretary an advisory committee to be known as the Advance Care Planning Advisory Council (in this section referred to as the ''Council'').

(b) DUTIES.—

(1) MISSION.—The Council shall advise the Secretary regarding the compilation, development, and dissemination of resources for developed with grants awarded under section 9.

(2) RESPONSIBILITIES.—Responsibilities of the council include the following:

(A) Ensuring that resources provided contain unbiased information about the range of options available to individuals with serious, chronic progressive, advanced, or terminal illness, including information about conventional, curative treatments, palliative care, and hospice care.

(B) Developing strategies for increasing public understanding about serious, chronic progressive, or advanced illness and the important role advance care planning can play in documenting an individual's wishes for medical care for loved ones in the event that the individual cannot communicate such wishes.

(C) Compiling information for dissemination regarding existing advance care planning models including POLST, advance directives, and healthcare proxies.

(D) Promoting interagency coordination and minimizing overlap regarding advance care planning, including opportunities to coordinate efforts between the Federal agencies and external stakeholders.

(E) Identifying and evaluating cross-cutting issues such as pediatric end-of-life care and advance care planning access issues.

(c) MEMBERSHIP.—

(1) IN GENERAL.—The Council shall be composed of up to 15 members appointed by the Secretary from among qualified individuals who are not officers or employees of the Federal Government.

(2) GROUPS.—The members of the Council shall include the following:

(A) At least 3 members with clinical training and an expertise in palliative care, advanced illness, or end-of-life care.

(B) At least 3 members from patient and family advocacy groups.

(C) At least 3 members from religious or spiritual organizations.

(D) Other members from interested stakeholder groups with a proven expertise in palliative, chronic, advanced, or end-of-life care.

(d) APPLICABILITY OF FACA.—The Council shall be treated as an advisory committee subject to the Federal Advisory Committee Act (5 U.S.C. App.).

SEC. 11. ANNUAL REPORT ON MEDICARE DECEDENTS.

The Secretary of Health and Human Services shall issue for each fiscal year (beginning no later than fiscal year 2018) an annual report that analyzes the circumstances of Medicare beneficiaries who died during the fiscal year covered by such report. Such analysis shall include at least the following with respect to such decedents:

(1) Information on the care or payor settings (such as under part A or part C of Medicare) at the time of death.

(2) Information on the demographic characteristics of such decedents.

(3) Information on the geographic distribution of such decedents.

(4) An evaluation of the Medicare claims data for such decedents for services furnished in the last year of life, including an analysis of the setting of care for decedents who had more than one chronic illness at the time of death.

(5) Such other information as the Secretary deems appropriate.

SEC. 12. RULE OF CONSTRUCTION.

Nothing in the provisions of, or the amendments made by, this Act shall be construed to limit the restrictions of, or to authorize the use of Federal funds for any service, material, or activity pertaining to an item or serv-

ice or procedure for which funds are unavailable under, the Assisted Suicide Funding Restriction Act of 1997 (Public Law 105–12).

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